Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS423AGC	A. BUILDING _____ B. WING _____	R 08/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERESIANE ADULT GROUP CARE	6620 ELLERHURST DRIVE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a follow-up survey conducted in your facility on 8/16/10 after a high level deficiency was identified in a previous survey. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for ten Residential Facility for Group beds for elderly and disabled person and/or persons with mental illness, Category I residents. The census at the time of the survey was ten. The following deficiencies were identified:	Y 000		
Y 176 SS=F	449.209(4)(c) Health and Sanitation-Insects, Rodents NAC 449.209 4. To the extent practicable, the premises of the facility must be kept free from: (c) Insects and rodents. This Regulation is not met as evidenced by: Based on observations and interviews on 8/16/10, the facility failed to keep 1 of 2 bathrooms and the kitchen free from insects (dead and/or live roaches observed in the kitchen	Y 176		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS423AGC	A. BUILDING _____ B. WING _____	R 08/16/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERESIANE ADULT GROUP CARE	6620 ELLERHURST DRIVE LAS VEGAS, NV 89103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 176	Continued From page 1 area and 2nd bathroom). Severity: 2 Scope: 3	Y 176		